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MONTANA HEALTH PLANNING NEWS

Volume 1, Number 5 — March/April, 1976

Health Data Management System

On March 17, 1976 a preliminary ad hoc committee meeting was held to discuss the development of a Montana Health Data Management Systems (MHDMS). Representatives were present from seven governmental departments and several private agencies.

The data management system is being developed in order to comply with the health data management requirements of the new Health Planning and Resource Development Act of 1974 (PL 93-641). The health data management system would, according to the law, entail identification of data requirements, sources, and availability, as well as the development of data acquisition protocols and acquisition, maintenance, and update of needed information and data. The law also calls for the organization, storage, and retrieval of data, and the coordination of activities with other agencies.

The purpose of the preliminary ad hoc committee meeting was to lay the groundwork for the coordination of activities of the various state and private agencies who work with health-related data.

It was established at the meeting that one responsibility of the committee would be to insure that the system incorporates the interests of both the producers and users of health data.

With respect to specific tasks, the committee agreed that one of the first priorities of the system would be the development of a data inventory of all health information now being generated in the

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PROPOSED REDUCTION IN HEALTH EXPENDITURES

As part of President Ford's plan to reduce Federal health expenditure, the Administration has proposed a plan, referred to as the "Financial Assistance for Health Care Act," which would virtually eliminate the categorical health programs. The programs that would be consolidated into a $10 billion health revenue sharing block grant would fall into four basic categories:

1. Medicaid;

2. Public Health Service preventative and community health programs which include community health centers, migrant health centers, community mental health centers, alcoholism, venereal disease,, immunization, rat control, lead paint poisoning control, maternal and child health, family planning, emergency medical services and health grants to states;

3. Health planning and medical facilities construction (authorized under PL 93-641); and

4. The developmental disabilities program.

The Administration's "Financial Assistance for Health Care Act" (H.R. 12233) has been introduced "by request" in the House of Representative Harley O. Staggers (D-W. VA), Chairman of the Interstate and Foreign Commerce Committee, and Representative Samuel L. Devine (R-Ohio).

The "Financial Assistance for Health Care Act" is targeted toward improving health services to needy by giving the states responsibility for distributing the block grant funds. The proposal gives states broad latitude in defining income and other eligibility requirements and imposes few federal controls on the performance of the states as they distribute the funds. To avoid disruptions, programs currently receiving federal funds would be protected from major reductions during the first three years of the "Financial Assistance for Health Care Act."

If the proposed legislation is accepted by Congress, states would have to develop and submit health care plans — which reflect public participation — as a condition of receiving federal funds for health concerns. No state matching funds are required under the block grant program, but states would be expected to fund health programs at 1975 budget levels. States would also have broad latitude in imposing reimbursement and cost-sharing levels of service.

The Administration block grant proposal drew sharp criticism from Congressional leaders. The major objections center on the inclusion of Medicaid and the amount of federal funds to be allocated. It is anticipated that the Administration's proposal will encounter rough going in the Congress. Congressional committee's have a stake in the categorical programs and although they are extremely unlikely to propose substantial increases in these programs, they are unlikely to be willing to phase them out. Some critics view the Administration's program as a retreat from the national standards for medical care to the poor which have been imposed through Medicaid. Most fundamentally, the Administration's proposal has been criticized as a budget control mechanism rather than a true cost control measure. Medicaid costs have been ris-

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HSA STATUS IN MONTANA

On January 4, 1975, President Ford signed the Health Planning and Resource Development Act of 1974, PL 93-641. This Act authorized a $1 billion three year program on health planning and resources development. The new authority attempts to build on past experiences of the Hill-Burton, CHP and Regional Medical Programs, seeking to combine their best features into one new health planning and resources development program.

The Governors of each state were requested by HEW to designate an area or areas for the purpose of health planning. After reviewing the proposals for designating a five area, three area or one statewide area, Governor Judge designated the State as one area. It was on September 2, 1975 that HEW published the designation of Montana as one health service area.

In October of 1975, the Federal regulations were published on the HSA's. The funding cycles established were as follows:

	CYCLE I	CYCLE II
Letter of Intent	12- 1-75	12- 1-75 & 2-1-76
Application Submission	1-19-76	4-16-76
Governor's Recommendation	2-18-76	5-17-76
DHEW Decision	3-31-76	6-30-76

Following the Governor's designation, two non-profit private corporations were formed in Montana to apply for designation as the Health Systems Agency.

One organization was formed by representatives of the physician/hospital provider group and the other formed by representatives of the Areawide Comprehensive Health Planning Councils.

In August the two groups began a series of negotiations and later merged their interest in order to present one HSA application for designation. At that time it was decided to use the name Montana Health Systems Agency, Inc., for their submission on the application.

According to PL 93-641 the HSA must have a governing board of 10-30 members, the majority of whom must be consumers. The governing board may be larger if it establishes an executive committee of not more than 25 members and meets the consumer/provider requirements.

On November 18, 1975, a selection process for the governing board was completed and a tentative makeup of the governing board was prepared; not all positions were filled at that time and were left open for selection. Provider membership numbered 15; consumer membership was 16, a total of 31 members.

In compliance with the Federal Regulations, MHSA Inc., submitted a Notice of Intent to the Governor on November 26, 1975, formally declaring their future plans to apply for designation and funding as the HSA for the State. At this time they declared the Cycle I funding deadline of January 19, 1976.

On December 12, 1975, the proposed board met for the first time in Billings, Montana and adopted bylaws for the Agency. At this time American Health Systems, Inc., a consulting firm, was hired to prepare the application to HEW. Prior to submission the Agency was required to hold a public hearing for comment on the contents of the proposed application and bylaws.

On January 9, 1976, the required public hearing was held in Helena. Citizen participation at the hearing was greater than anticipated, and many requests for change or alterations were made. In order to act upon these requests, it was necessary to change the funding cycle to Cycle II. On January 28, 1976, a second Notice of Intent was filed for the second review cycle.

On January 10, 1976, the Working Committee met with the Governing

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REDUCTION — from page 1

ing rapidly for two reasons: 1) the number of beneficiaries has been in increasing (largely because of increased unemployment), and 2) the cost for all medical services including Medicaid services has been increasing much more rapidly than the consumer price index. The Administration's block grant proposal does not solve either problem. It simply transfers both of them to the states by placing a fixed ceiling on federal spending.

Evaluating the combination of Medicaid with other community health programs, as proposed with the Administration's block grant approach, the Association of State and Territorial Health Officers (ASTHO) Executive Committee concluded "that it is not possible to couple a fee-for-service reimbursement for a care program with disparate but essential major preventive community public health programs, and put a ceiling on the total and expect the latter to survive."

With a back log of major proposals to be taken care of and limited time left before campaign demands consume Congress, it is doubtful that the enactment of this substantial new legislation can be considered within the normal budget process for FY 77. It is highly doubtful, most observers feel, that Congress will give the health block grant proposal a thorough examination before members leave to campaign in this Presidential election year.

Still the proposal is an important one and is likely to be discussed again either by itself or as a part of a larger package.

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Views and Comments are welcomed. Address letters to the Editor, HEALTH PLANNING NEWS, Cogswell Building, Helena, Montana 59601.

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Editorial Assistant	**Carolyn Gordon**
Photography	**Betty Cooksey**

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Board to discuss the modifications of the application. The Governing Board was increased to 40 members — twenty-one (21) consumers and nineteen (19) providers. As a result of the expansion in the Governing Board, an Executive Committee was formed as required. The Committee consisted of 16 members from the Governing Board. Elections of the proposed Executive Committee were held and provider and consumer positions were made. The Executive Committee was appointed to serve a dual function for the Agency: 1) as the Executive Committee to the HSA Governing Body and 2) as the State Health Coordinating Council.

On February 27, 1976, the Governing Board met to review, revise and approve the draft of the Conditional Grant Application. The application was discussed on a page by page basis. Changes to the proposed plan were reviewed and the consultant, Mr. Peck, was instructed to make the proposed changes and re-submit the corrected plan to the board members. The Governing Board increased to 42 members, twenty-two (22) consumers and twenty (20) providers. Appointments to the Board and Executive Committee which were not previously filled were recommended for approval.

On March 12, 1976, at 9:05 a.m. the public hearing was held in Helena to receive public comment on the second draft of the proposed HSA work plans.

The hearing progressed smoothly and constructively. At 10:15 a.m., the meeting adjourned and the Executive Committee met to discuss the comments presented by the public at the hearing. Discussion regarding the authority of the Montana Health Systems Agency as opposed to the authority of the State Department of Health and Environmental Sciences was of considerable importance to the Committee. Limitations to the size of the Governing Board were made; a maximum total of 42 members was exercised.

On March 26, 1976, the Governing Board met once again to review the comments made at the March 12 public hearing. Revisions in the proposed work plans and approval

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C.A.T. Scanner Group Formed

Montana is soon to enter into a new era in radiological technology. The device which is introducing this new era is called the Computerized Axial Tomography Scanner (CAT Scanner). The CAT Scanner is a sophisticated x-ray and computer system which, through its ability to pick up extremely small differences in tissue density, can produce three-dimensional pictures of the brain or of a certain portion of the body.

Clinical testing of the brain scanner showed that it offered views of the brain which previously were not visible or only poorly so with prescanner techniques such as conventional x-rays, nuclear scans, angiograms and pneumoencephalograms. In doing so the brain scanner helps neurologists better diagnose brain tumors, blood clots, lesions of the optic nerve and other brain abnormalities.

Following the introduction of the EMI brain scanner there has been a veritable flood of technological advances in computerized tomography, resulting in the second and third generation full head and body scanners now on the market. CAT scans of the body are performed the same way as are brain scans; the scanner rotates around the body while sending out thin x-ray beams. As these beams pass through the body they are picked up by a sodium iodide crystal on the other side. The crystal digitizes the amount of radiation, and the information is fed into a computer. The computer through a process of simultaneous equation solving comes up with a co-efficient of x-ray absorption for each part of the body scan. The computer then gives a digital read-out of the different densities of the area scanned. Each density value is precoded to show a different shade of grey (or color on color pictures) and the computer finally arrives at a three dimensional picture of the area scanned.

The body scanner is able to picture bones, organs and tissues much better than conventional x-ray and should revolutionize the diagnosis of various bodily ailments, such as the enlargement of, or changes in, bone, organs or tissues caused by cancer, heart disease, lung disease or other illnesses.

The full potential of body scans is not yet known, and certain diagnostic problems have been encountered. While head scans are directed at a confined space with very specific symptom complexes, body scans must cover a large space with diverse symptom complexes. Also, the brain's two halves have a high degree of symmetry making clinically significant aberrations easier to recognize in the head than in the lower body.

Future clinical work with body scans should eventually solve the diagnostic problems which have been encountered. To date the greatest amount of study has been done on the abdominal area of the body and there has been considerable success in the diagnosis and study of both benign and malignant tumors of that area.

There have presently been two applications submitted for the machine in the State. The applications, however, arrived prior to the development of standards and criteria on the machine.

North Central Areawide Health Planning Council (NCAHPC) conducted a review on the proposal from Columbus Hospital and then sent their recommendations to approve the purchase of the scanner to the State Office of Health Planning and Resource Development.

Shortly thereafter, Deaconess Hospital in Great Falls submitted their application and were turned down by NCAHPC and the State Office, mainly on the basis of being financially obligated to the rebuilding of their hospital. Deaconess appealed the areawide and State decision to the State Board of Health. Due to lack of criteria for standards on the body scanner, the decision is now pending until further measures have been established.

Under the certificate of need law and 1122 review process, the Division of Health Planning and Resource Development is obligated to review most construction, renovation, changes in service and purchases

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state. The inventory would list what data is being collected, by whom it is being collected, and how it can be accessed. This information would be maintained and the inventory updated periodically by the Bureau of Records and Statistics of the Department of Health and Environmental Sciences.

It was also noted that the Records Management Bureau of the Department of Administration is attempting to secure financing for a statewide data inventory. The health data inventory will not be initiated until it is ascertained that there would be no duplication of effort.

It was decided that the committee would meet again when the following tasks have been performed: 1) The drafting of a flow chart illustrating how the health data management system will function, 2) The contacting of the Department of Administration to insure that there is no duplication of effort, and 3) The exploration of funding possibilities to effect early start up of the system.

HSA — from page 3
of the **final** Conditional Grant Application were made.

Mr. James Ver Duft, from the Denver Regional Office, stated that the final Health System Regulations on HSA's had been signed by the Secretary. The notice of proposed rule making for the State Health Planning and Development Agencies was also available. Mr. Ver Duft stated that the amount of funding available for the HSA in Montana is $175,000.

On April 12, 1976, according to the MHSA, Inc. organizational calendar of events, the Agency will be mailing their final Conditional Application to the appropriate Federal, State and local offices.

After the Governor has received the final Conditional Application he will submit his recommendation, by May 17, 1976, to the Department of Health, Education and Welfare. The DHEW will have the results of their decision by June 30, 1976.

Anyone wishing a copy of the Governing Board and Executive Committee members or minutes of the mentioned meetings or hearings should contact: Betty Cooksey, Division of Health Planning and Resource Development, State Department of Health & Environmental Sciences, Cogswell Building, Helena, Montana 59601.

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SCANNER — from page 3
of new equipment in hospitals and nursing homes.

The State Facilities Committee of Health Planning and Resource Development recommended that a separate committee be organized to investigate the necessity and/or practicality of more than one machine for the State and to also develop standards for reviewing incoming applications.

Committee members chosen were those most familiar with the situation, those who would be working in an analogous position in the future and who could also provide the State with extra assistance on the topic. The CAT Scanner Committee is composed of:

Two hospital administrators:
- Doug Atkinson, Holy Rosary Hospital, Miles City.
- William Hansen, Central Montana Hospital, Lewistown.

Two radiologists:
- Verner Albertson, M.D., Bozeman.
- L. C. Brewton, M.D., Havre.

One Consumer:
- Mrs. Pat Gilfeather, Helena.

Ken Rutledge, Health Planner of the Health Planning Bureau, Health Planning and Resource Development, and Vearle Addy, North Central Areawide Health Planning Council, are assisting in the development of the Committee.

The first meeting of the CAT Scanner Committee on standards and criteria was held on February 3, 1976. The meeting was opened with an introduction by Robert R. Johnson, Administrator of the Health Planning and Resource Development Division.

Due to the lack of documentation on the **body scanner,** the Committee agreed that their major area of concern would be the setting of standards and criteria for the CAT body scanners. Some of the tasks for determining the standards are: 1. Contacting facilities already using body scanners, 2. Information on actual utilization or potential utilization, 3. Specifics on x-ray procedures that have been performed or may be performed by the body scanner, 4. Cost comparisons in relation to standard x-ray techniques, and 5. Number of procedures the machine must perform so that the hospitals do not operate at a loss.

Collecting the data will be harder than one would expect. Knowledgeable material is very limited or just not available at this time. After these tasks have been completed a questionnaire will be drawn up and sent to all hospitals in Montana with 100 beds or more. The questionnaire will request the number of procedures performed by standard x-ray techniques, exploratory surgery, etc., for body examinations.

With the help of a radiologist these procedures will be translated and evaluated for comparison with the findings on the full body scanner.

The Committee will be meeting again sometime in early May to discuss the development of this research and the questionnaire.

CORRECTION

Some of you might be wondering how the March-April edition of our newsletter preceeded the January-February issue. Well it was an error on our part and we do apologize for the confusion. **This** is the March-April edition and the one previously printed Volume 1, Number 5 — March-April 1976 is your January-February edition. Sorry!

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MONTANA HEALTH PLANNING NEWS

Volume 1, Number 3 — November-December, 1975

Health Data Management Report

The Health Planning and Resource Development Division has published the Montana Health Data Management System report, prepared with the assistance of John Short and Associates, which outlines the initial development of a health data base to be used by health planners and decision-makers in projecting health care needs in Montana. Rather than attempt to establish a huge, centralized library where all health data is stored, the report attempts to describe the health data already being collected by various agencies, its potential uses, and the integration and analysis of the existing data bases.

The report outlines the sources and potential application of five components of the health data system: Demographic and Socio-economic Data, Health Manpower Data, Health Facilities Data, Utility Data, Vital Statistics, Financial and Cost Data. A section on System Management recommends that the Bureau of Vital Statistics of the State Department of Health and Environmental Sciences assumes the technical responsibility for the system which would involve: maintaining the data files, monitoring and integrating existing data collection efforts, and updating the data in the system on a regular basis. The bureau would charge a fee of users to support the system. Further recommendations outline the development of a cooperative Data System Advisory Committee, which would involve groups generating health data as well as groups using health data. The Committee would meet regularly to discuss data needs and the opportunities for additional pooling of data collection efforts.

The final section titled Technical Description describes the computer files and programs designed and tested by John Short and Associates, Inc., and demonstrates the kinds of information which can be stored or retrieved from these files.

Information collected from annual reports submitted by each hospital and long-term care facility in Montana was computerized for 1972, 1973 and 1974. Information for each hospital regarding staffing, admissions, beds, inpatient days and percent occupancy was collected and is now available on tape. Nursing home information includes the number of licensed beds, number of admissions, discharges, patients, patient days, and per diem costs.

Physician data, collected from licensing forms required by the Department of Occupational Licensing, was also put on computer tape. The information on physicians includes: Current address, date of birth, medical school, specialty, and previous addresses.

The report provides an entry point for further development of a state health data system. Future data needs will require additions to the system in light of the data requirements of PL 93-641.

The recommendations of the report will be pursued while efforts will continue in the area of updating and adding to the current health data system.

Computer files and tapes are being maintained by the Bureau of Records and Statistics of the State Department of Health and Environmental Sciences.

Anyone wishing a copy of the report should contact: Betty Cooksey, Division of Health Planning and Resource Development, State Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59601.

Health Care Costs At Record High

The average American spent a record $547 for health care during fiscal 1975, the Department of Health, Education and Welfare recently reported. The nation's total expenditure of $118.5 billion during the year ending last June 30 was 13.9 per cent above the previous year.

A report prepared by the Social Security Administration said that health accounted for 8.3 per cent of the gross National Product, after three years of being stabilized at between 7.7 and 7.9 per cent. Health's sharply higher share of the combined value of the nation's goods and services was attributed to a slow down in the GNP growth rate at the time when health care costs were escalating and more persons were seeking treatment.

Public spending in 1975 reached almost $50 billion or 42 per cent of the total, primarily through Medicare for the aged and Medicaid for the poor. That was 22.2 per cent higher than the previous year.

Hospital care accounted for $46.6 billion or 39 per cent of total health spending. Physicians' services ranked second at $22.1 billion or 19 per cent.

CHP ADVISORY COUNCIL

On October 23, 1975, the Montana Advisory Council for Comprehensive Health Planning held a meeting in Helena. The main topic of discussion centered around local, state and national progress on the implementation of PL 93-641, the National Health Planning and Resource Development Act.

A panel discussion on HSA development, moderated by John Short of John Short and Associates, Salt Lake City, opened the meeting. The two non-profit private corporations which formed to vie for the HSA designation were represented. Panel members included: G. Brian Zins, Dr. John McMahon, Bill Leary and Gene Nixon, from Montana Health Systems Agency and Ralph Gildroy and Ed Morse from Treasure State Health Systems Agency.

The panel discussed the progress of the negotiations between the two groups and the main concerns of the groups throughout the series of joint meetings that had been held. "It looked like we were completely opposed to each other, and yet we were coming at the same point from a different direction," Morse stated.

John Short, President of the consulting firm hired to assist the two groups during the negotiations, outlined the progress to date. "We have come to the point where we have prepared a draft set of bylaws for the organization — the proposed organization — and those bylaws have been or are being disseminated to each of the various groups involved to get their reactions, comments, and concerns."

Primary issues during the negotiation sessions centered upon membership and selection of the HSA governing board and the use of subarea councils. A proposed set of bylaws was developed which outlined the overall plan for the proposed HSA.

The bylaws call for five subarea councils which will be advisory to the governing board, except for reviews carried out at the areawide level. In these situations the governing board may override a positive recommendation of a subarea council by a simple majority whereas a ⅔ majority of the governing board is needed to override a negative subarea decision.

Existing areawide CHP Councils will select initial governing board consumer representatives and area professional associations will be responsible for selecting provider board members.

Once the bylaws are finalized, the joint group, which will be known as the Montana Health Systems Agency, will move ahead with the application process which includes a requirement for public meetings to allow for public review of the application.

Panel Discussion

Many in attendance raised concerns about the proposed makeup of the HSA governing board. There was some feeling that there was not adequate representation of various groups. In response, Dr. McMahon pointed out that "you would have a board of 200 people to include direct seating for everybody."

Dr. Anderson of the Department of Health suggested that "people who don't like what they hear have two options: 1) they can try to persuade the people that generated this (Montana Health Systems Agency) to change or 2) they can form something of their own that would be competitive."

Next on the agenda was Mr. James Ver Duft, Chief, Health Planning Branch, Department of HEW, Denver, who discussed the national trends regarding the implementation of PL 93-641. Ver Duft said that this piece of legislation was not intended to maintain the status quo. "The intent is quite obvious," he said, "and that is to provide access to quality care at a reasonable cost."

"The law creates 3 entities, each with separate functions," Ver Duft said. These entities are a State Health Planning and Development Agency, a Health Systems Agency and the State Health Coordinating Council. These entities must work together so the sum of the parts will equal a unified approach to statewide health planning and resource development.

"This piece of legislation very definitely places decision making responsibility on health at either the State or the HSA level . . . it precludes Federal involvement until such time as a recommendation is made by one of the three entities."

Ver Duft went on to elaborate on the recently published Federal regulations regarding the Health Systems Agency. He outlined four primary functions which the HSA must concentrate on during the first year of funding:

1. Plan Development
2. Plan Implementation
3. Data Management
4. Agency Management and Support Services.

"During the first year, one of the critical issues is going to be to come up with a transition strategy," Ver Duft stated. The Federal Government, according to Ver Duft, plans to provide a great deal of technical assistance to facilitate the development of strong, new agencies.

Although the regulations basically follow the legislation, Ver Duft outlined some "provisions and interpretations not included in the law." For example, the Governors of each state will be given far greater control in the selection of the HSA. Each will be given 30 days to review any HSA applica-

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"Rural Health Initiative"

The "Rural Health Initiative" (RHI) is a program proposed and developed by the Glendive Community Hospital. The main function of the program is to expand the availability of health care resources to a presently under-served eight-county rural **target area** encompassing Carter, Dawson, Fallon, Garfield, McCone, Prairie, Richland and Wibaux counties.

Four major components of the system are:

1.) **Physician Treatment Teams** — A team of six multidisciplinary physicians will be recruited. This team, along with other paraprofessionals, will be based at Glendive Community Hospital. The team will travel throughout the target area on a defined weekly schedule providing primary health services to the area's communities. Glendive Community Hospital will contract with each of the area's respective communities to make members of this health care team available for on site diagnostic treatment, consultation and referral services. Other functions will also be incorporated when the program is operational.

2.) **Community Health Nursing Program** — Modeled after a community nurse project funded in Eastern Montana by the Old West Regional Commission (OWRC), the system proposes to use six nurses to serve in a primary intake capacity in their respective communities. Under the RHI this program would be expanded to include those rural areas over 125 people without a full-time physician. The four additional community health nurses would join the two already in the area.

All six will receive specific training to interface with the remaining components of the proposed model. These community health nurses would provide first aid, emergency care, preventive medical and home health services to their respective communities.

Finally, these nurses will serve in an outreach capacity, referring and scheduling local patients for the team of physicians which will serve the eight-county target area.

3.) **Centralized Administrative Unit at Glendive** — To reduce cost and utilize the existing area medical expertise and resources, administration for the proposed rural health care delivery system will be provided by professional staff from the Glendive Community Hospital. Mr. Phil Auble, Hospital Administrator, will assume overall responsibility for the project. Team physicians will be under the direct guidance of the present hospital medical director. Laboratory functions, nursing services, radiology, etc., will be managed by hospital staff presently responsible for such functions. Additional benefits gleaned from the program include: centralized billing and bookkeeping, centralized purchasing of equipment and supplies, centralized recruiting and personnel administration activities.

4.) **Health Services Contracts** — Contracts for service will be the mechanism which will link the physician team, the community health nurses and the project administration to the target area. A flexible agreement, drawn up in the 90-day pre-operational period, will establish the levels of health services to be provided by the HURA/ Rural Health Initiative to each of the area's communities.

On October 23, 1975, the Economic Development Association of Eastern Montana (EDAEM) held their fall quarterly meeting. One important topic discussed was the RHI. Rich Eudy, Health Coordinator, acted as moderator of a panel discussion on the initiative. Panel members included: Mr. Wes Toepke, Mrs. Carol Swanson, Dr. J. O. Brown, and Phil Auble.

Representatives of various surrounding areas raised concerns over the implementation of the initiative. Some physicians felt the purpose was worthy but disagreed with the transient form of health care delivery offered; others felt that there had not been sufficient dissemination of information regarding the proposal prior to funding.

As a result of the panel, another public meeting was held on November 13, 1975, in an attempt to iron out the differences which had been raised. All area physicians, administrators and hospital board members were invited to attend. Those in attendance included:

Four area physicians:
- Dr. R. E. Thompson, Glendive
- Dr. T. J. Mollee, Glendive
- Dr. L. A. Compodonico, Miles City
- Dr. S. A. Olson, Glendive

Two hospital administrators:
- Ralph Johnson, Sidney
- Doug Atkinson, Miles City

One dentist:
- Dr. L. M. Moline, Glendive

Representatives for the RHI were:
- Wes Toepke, President of the Board of Director of Glendive Community Hospital
- Phil Auble, Vice President of the Board of Directors and the Administrator of Glendive Community Hospital and
- Dr. J. O. Brown, Jr., Glendive.

The lack of physician input in formulating the initiative proposal and the absence of physicians on the present policy-making boards were of primary concern to the physicians attending. One suggestion offered by physicians was to limit the recruitment of specialists and to enhance the recruitment of general practitioners and primary care physicians.

While no concrete decisions were reached, it was agreed that there would be future meetings of this type to allow a forum for providing information on the progress of the project and for attempting to address the concerns of area health providers.

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Editor	**Betty Cooksey**
Editorial Assistant	**Carolyn Gordon**
Photography	**Betty Cooksey**

Anderson Named to Executive Board

Dr. John S. Anderson, Administrator of the Division of Health Services, Department of Health and Environmental Sciences, was elected to the Executive Board of the American Public Health Association. Dr. Anderson, the first Montanan to be elected to the prestigious national Executive Board, will serve in a policy-making capacity for the APHA which represents over 50,000 public health people in scientific matters and in federal legislative activities.

Dr. Anderson said his election to the Board at the annual meeting of the APHA in Chicago reflects the strength of APHA affiliates. The efforts of APHA affiliates who caucused in favor of his nomination were seen by Dr. Anderson as largely responsible for his election.

Dr. Anderson also serves on the Personnel Committee which is in the process of drawing up an affirmative action plan for APHA. As a member of the Executive Board, Dr. Anderson will attend the quarterly Board meetings held around the nation.

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NOTICE OF INTENT SENT TO GOVERNOR

On November 26, 1975, the Montana Health Systems Agency, Inc., formally submitted their Notice of Intent to the Governor for designation and funding as the HSA for Montana.

The next step is the application process which will be done with the assistance of American Health Systems, Inc., a consulting firm from San Francisco. The application must be submitted by January 19, 1976, to meet the federal deadline for Cycle I funding. Following are the funding cycles that have been established:

Notice of Intent:

Cycle I—12-01-75
Cycle II—12-02-75 and 02-01-76

Application of Submission:
Cycle I—01-19-76
Cycle II—04-16-76

Governor's Recommendation:
Cycle I—02-18-76
Cycle II—05-17-76

DHEW Decision:
Cycle I—03-31-76
Cycle II—06-30-76

The application, when submitted, will be reviewed by the Governor who will make a recommendation to the Denver Regional Office. Final designation will come from the Regional Office and is expected to occur by March 31, 1976.

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tion and make a recommendation to the Secretary of HEW (through the Denver Regional Office). Should the Secretary not accept the Governor's recommendation, he must provide the Governor with a detailed statement of the reasons for the decision.

Another HEW interpretation specifies that every HSA must go through a period of conditional designation.

Ver Duft then discussed regulations regarding HSA data systems, audits, application process and subarea councils. "Subarea councils provide a very viable mechanism. One of their very real functions is to provide representation to the larger Health Systems Agency Board," Ver Duft said. "However, if you look at resources available, if you look at the incredible tasks that must be performed, one wonders whether there will be enough resources to provide staffing of subarea councils . . ."

Following Mr. Ver Duft's presentation and a lengthy question and answer period, Bob Johnson gave a brief description of the new State Health Planning and Resource Development Division. Johnson noted that the Division was formed to prepare to undertake the functions required of the State Agency under PL 93-641. As yet, no regulations have been released regarding the State Agency, so the designation and development of the State Agency is still sometime in the future. The meeting concluded following a short business meeting.

Jim Ver Duft — DHEW

Anyone wishing further information regarding the HSA panel discussion or Mr. Ver Duft's presentation may write to the following address for a transcript of the proceedings: Division of Health Planning and Resource Development, Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59601.

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MONTANA HEALTH PLANNING NEWS

Volume 1, Number 2 — September - October, 1975

Taylor Appointed Correspondent for State of Montana

Dennis M. Taylor, Health Planner with the Division of Health Planning and Resource Development, has been appointed the correspondent for the State of Montana for the Georgetown Health Policy Center. As a member of the network of correspondents, he will be responsible for keeping abreast of health-related issues and policy developments including legislation, political decisions, administrative actions, and executive initiatives. As correspondent he will supply regular reports to the Health Policy Center on the status of Montana health reports, budgets, bills and other related health activities.

The Georgetown University Health Policy Center of Washington, DC, is a national service center for health policy makers funded by a grant from the Robert Wood-Johnson Foundation. The Center is designed to assist state, county and municipal governments in formulating and implementing health care policies through improved communication of information and ideas. It is intended to provide new resources for national health policy development through better understanding of the activities and capacities of state and local governments in relation to both private and federal health program efforts. The Center is an independent and neutral undertaking based outside of government but dedicated to stimulating and supporting effective governmental response to health problems and public needs.

The need for the Health Policy Center stems from the fact that health care policy making has become staggeringly complex.

Throughout the nation, health care planning and policy formulation are plagued by uncertainty. A lack of understanding of the policy-making process and the effects new policies have on existing programs is a major problem. The lack of insight about the behavior and response of critical political, economic and other social forces in the health care field frustrates effective implementation. There is an absence of a guiding national health policy, and even more critical, the absence of a means for recognizing policy directions. Further, a mutual distrust between the federal and state governments sometimes inhibits the effective discussion of these problems.

In the past decade, both the range of issues and types of relationships between various levels of government have changed dramatically.

The trends of the past decade show no signs of abating. Indeed, all indications are that the next few years will challenge the existing administrative structures and the decision-making capabilities of all levels of government as never before.

Unless interstate communication is improved and instate capacities strengthened, the ineffective results of the past will continue.

The Center's goal is to achieve more effective communication among states, and between the states and the federal government. The Center's main focus will be on service to state-level policy makers, but location in Washington will also facilitate communication of information received from the states to the relevant federal agencies and lawmakers.

Anderson Candidate for APHA Exec. Board

John S. Anderson, MD, MPH, former Director, Montana State Department of Health and Environmental Sciences, has been selected by the American Public Health Association's Nominating Committee as a candidate for a position on the APHA Executive Board. Nine individuals were nominated for consideration for the three vacancies occurring on the APHA Executive Board, to serve four-year terms. Elections for these national positions in the American Public Health Association will be held on November 19, during the annual meeting in Chicago.

Dr. John Anderson
—Jim Bond Photo

Northwestern Health Systems Plan Approved

On September 3, 1975, the Board of Directors of Northwestern Montana Areawide Health Planning Council gave final approval for publication of the Health Systems Plan for Region V.

The Plan is divided into six chapters. Some of these chapters have been sub-divided into related categories to expand upon the content of the chapter.

The input for the Plan came from several sources: the needs expressed during county health council meetings, technical advice and criticism by the Plan Development Committee and consultants from Arthur Young and Company; consumer and provider comments solicited from persons not on any particular committees; and professional staff work.

Chapter II "Description of the Region," discussed the geographic Demographic and economic characteristics of Region V. Region V has experienced a population growth over the last forty years, with Lincoln County showing a 44% increase in a period of 10 years. A major construction project — The Libby Dam —largely explains that county's increase. The completion of the Dam will mean a much smaller increase in population, if any, between 1970 and 1980. In the last forty years, a large portion of this population increase has been in persons 65 and older.

For planning purposes the increase in population in Region V means an increased demand for health services, but the shift in concentrations of population (less younger, more older persons) means a particular increase in demand for geriatric services and a possible decrease in demand for pediatric services.

Chapter IV "The Health Services System," provides a description of the current status, trends and problems and contains implementation recommendations concerning each component of the Health System. (There are three categorieis of recommendation: short term 1 year; intermediate 1-5 years; and long term 1-10 years.) There are also summaries of the implementation recommendations for each county, which will also serve as the county plans.

The **Special Services** section of the Plan, IV A6, contains discussion and recommendations regarding highly specialized medical service techniques. One recommendation states that the Burn Care Transfer Team be developed to the greatest capacity possible, so as to guarantee the best medical transient service to the patient. A Burn Care Unit in Region V does not appear to be the solution for burn treatment in the Plan's ideology because this would merely be a stopover until the patient is transferred elsewhere. Short Term Acute Care In-Patient Hospital, under **Intermediate Services** IV BI, shows a surplus of beds due to low occupancy rates in Missoula's three hospitals. The cost of hospital care in Missoula is higher than anywhere else in the region. (The levels of income are still below national level in this region.) The Plan recommends for support efforts aimed at bringing the bed capacity in Missoula in line with the need, which at this time means decreasing the number of acute care beds. The Plan notes that a reduction to two hospitals would be one means of achieving the desired number of beds. The **Primary Services** section C. 3, Public Health Services, shows a wide variance of public health services throughout the region, some with little or no services and others, as is the case with Missoula, a very high concentration of public health services. The Plan has emphasized the use of Multi-County Public Health Units. These Units, when and if in operation, could make available minimum public health staffing and services to the surrounding counties.

An important factor in implementing a public health program is communication. In the past this has not been a priority; now efforts are being made to encourage the Public Health Departments to publicize their services to all citizens and health professionals.

Chapter V "Other Major Health System Components," listed as one of their recommendations for the health manpower shortage in rural areas of the region, to support legislation concerning the status of Physicians Assistants and continued funding for the Nurse Practitioners' Program.

An integral part of the Plan development is the evaluation and updating of the final product. Much improvement and revision of the Plan will occur continually through suggestions from the Plan Development Committee, the Project Review Committee, the County Councils, local input and the Board.

At the end of each fiscal year the Board of Directors must approve the updated Plan.

The Plan in draft form has been sent to hospitals, advisory boards, medical associations, nursing homes, public health officials and county councils. Others interested in the Plan may contact:

Mr. Ed Mahn, Executive Director
Northwestern Areawide Health
Planning Council
Box 516
Missoula, Mt. 59801

MONTANA HEALTH PLANNING NEWS

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Editor	**Betty Cooksey**
Editorial Assistant	**Carolyn Gordon**
Photography	**Betty Cooksey**

Comings/ Goings

Jim Jasper, Editor and Photographer for The Health Planning News, resigned on September 30, 1975. Jim, has started his own business in the field of communication. The Health Planning and Resource Development Division wishes you the best of luck and success, Jim, and thank you for your past efforts.

Betty Cooksey has inherited the Newsletter responsibilities. She has been with the Division as a Research Aide since October, 1974.

In the last issue of Health

Charles Aagenes

Planning News you might recall the article on the "New Planning Division," that has now been formed.

The new Division Administrator is Robert R. Johnson and the two Bureaus composing this Division are:

1) Health Planning Bureau — Leslie Taylor, Acting Bureau Chief
2) Resource Development Bureau — Wallace M. King, Bureau Chief.

Other new members under the Division are: Charles Aagenes, Hospital Construction Consultant, coordinates the development of the Hill-Burton State Plan for the construction of hospital and medical facilities in Montana; Leo Krisl, Hospital Consultant—reviews all construction plans for hospital and medical facilities in Montana to see that they meet all building codes and specifications of the state and conducts onsite inspection of stage development on all Hill - Burton construction; Bert Glueckert, Hospital Facility Consultant — coordinates the administration of the 1122 Review Process and Certificate of Need Program for Montana; Georgia Barker, Secretary, joining the Division's secretarial staff.

Leo Krisl

Implementation Development of Title XVI

Mr. Wallace A. King, Chief, Resource Development Bureau, was one of approximately seventy individuals in the nation — and the only person from Region VIII — invited by the Division of Facilities Development, DHEW, to participate in a Title XVI, PL 93-641 workshop in Rockville, Maryland, on September 10 and 11, 1975.

Purpose of the workshop was to assist the Federal officials in identifying issues of critical importance to the development of regulations for the implementation of Title XVI, PL 93-641.

The participants were divided

Wallace King

into four work groups: (1) Definition, Standards, Technical Assistance, (2) Assurances and Monitoring, (3) Financial Assistance, (4) Agency Functions. The objective of each work group was to identify possible options for solving problems arising out of the implementation of the facilities development aspects of Title XVI.

From the preferred options, agency staff will develop specifications from which the proposed regulations will be developed.

Mr. King participated in the Financial Assistance group which was concerned with the implementation of the Grant and Loan programs, establishment of priorities, reallocation of allotments, categorization of grants and loans, eligibility of Indian tribes for financial assistance, repayment period for loans, special projects under Section 1625, appeals and limitations of Federal participation.

"This is probably the first time the DHEW has requested input and assistance prior to the publishing of draft regulations from such a diverse group of interested persons. How successful the group was in guiding the content of the regulations will not be known until the draft regulations appear in the Federal Register," King stated.

Persons or groups interested in the implementation of Title XVI are encouraged to send written comments to Mr. Edgar N. Duncan, Director, Division of Facilities Development, DHEW, Rockville, Maryland 20852.

A.M.A. Seeking Substitute M.D.'s

The American Medical Association is seeking physicians to substitute for up to four weeks for regularly assigned family practitioners in the National Health Service Corps (NHSC) and the Indian Health Service (IHS). The AMA program, Project USA, places volunteers allowing NHSC and IHS physicians time off to take vacations or attend coures. Professional liability insurance coverage is provided for doctors who volunteer. Interested doctors should contact John Naughton, AMA, 535 North Dearborn, Chicago, Illinois 60610.

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ENVIRONMENTAL HEALTH WORKSHOP

At a September 26 workshop held in Helena, the Environmental Health Committee met with health representatives to discuss the Environmental Health Section of the State Plan for Health.

Participants in the workshop, which was designed to evaluate the Environmental Plan as a working document, included members of the Department of Health and Environmental Sciences, representatives from private health organizations, sanitarians, local officials, a State Board of Health representative and local planners.

It was concluded that the Plan was a useful document particularly for the members of the Health Department as it provided an opportunity to jointly develop a method of accomplishing objectives considered important for environmental health.

Participants Discuss Environmental Health Plan

Criticisms of the Plan included: the difficulty of measuring direct impact, lack of a specific implementation procedure for each objective, and failure of the Plan's development to allow the Environmental Sciences people the opportunity to critically review their own ideas, concepts, and approaches to implementation incorporated within the Plan.

The matter of whether or not health concerns should be considered along with environmental issues was discussed, and it was decided that health should be considered as an essential element not to be separated from environmental planning.

Several participants indicated that environmental health responsibilities are becoming increasingly proliferated among sundry groups and agencies. Such a process, it was charged, has lead to fragmentation and serves to inhibit the effectiveness of environmental health programs and planning.

As a result of the workshop, the following conclusions were jointly reached by the Environmental Health Committee, the Division of Health Planning and Resource Development, and participants at the workshop.

1. **The Environmental** Health Sub-committee of the Advisory Council to Comprehensive Health Planning should continue functioning. (With the inception of the new national health planning legislation, Comprehensive Health Planning will cease to exist.) Its membership should be enlarged to form a more influential and well-represented group. It should more directly relate to the Department's Environmental Sciences Division. Ben Wake, Administrator of the Environmental Sciences Division, indicated he will get more involved with and provide support to the Committee which, he said, should become more active in the operations of his Division.

2. **The specific** functions of the Committee should include a coordinating role to point out problems caused by duplication of efforts at the state and local levels.

3. **Several members** of the Department indicated their doubts as to whether or not the public had an adequate understanding of and interest in the Division's environmental health functions. One suggested function of the Committee could be to act as a liaison between the Department and the public's interest.

4. **The Environmental Committee** would assist the Environmental Sciences Division in critiquing its ideas and objectives, prioritizing those objectives, and offering alternative methods of accomplishing them.

5. **It was** determined that the Committee could be most effective by assisting in the establishment of the objectives, offering alternatives and conveying the ideas and suggested coordinating procedures to the Division and the Department.

6. It was indicated that the Environmental Sciences Division would in the future develop its own plan which the Committee could then review.

Approximately 27 participants attended the workshop.

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MONTANA HEALTH PLANNING NEWS

Volume 1, Number 1 — July-August, 1975

Groups to Seek HSA Designation

Two newly-formed corporations are preparing their applications for designation as the Health Systems Agency (HSA) for Montana. Members of the boards of the Comprehensive Health Planning Areawide Agencies have formed the Treasure State Health Systems, Inc.; and a group of providers primarily from Helena has formed the Montana Health Systems Agency, Inc.

Although the two groups have different representation and their members have for the last several years espoused different philosophies, it appears that they both have the same basic commitment to increasing the quality of medical care and services in the state.

While both organizations are being careful not to align themselves within the ranks of consumers versus providers, the issues of local citizen involvement, local decision-making, and organizational structure have emerged as the present points of diversion between the two groups.

Ed Morse of Denton, Board Chairman of the North Central Montana Health Planning Council and new Chairman of the Treasure State Corporation, says that he and the new organization are primarily concerned about the fate of local decision-making in the health planning process.

"We formed the Treasure State Health Systems because we saw it as the only way to assure that local needs are governed by local control," Morse said.

Morse, who is a rancher, cited the 1122 areawide reviews of medical facilities construction as an example of the kind of decision-making capabilities which the

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EASTERN AREAWIDE COMPLETES HEALTH PLAN

Eastern Montana has recently published the first areawide health plan in the state. The plan is a culmination of efforts begun in March with the establishment of a Health Planning and Coordinating Subcommittee of the Economic Development Association of Eastern Montana's (EDAEM) Executive Board.

Working closely with that Committee were the EDAEM Health Planning staff, three district Facilities Committees and numbers of interested citizens of Eastern Montana who attended various public meetings held throughout the region which invited citizen input for the plan.

John Short and Associates, a consulting firm from Salt Lake City, Utah, was retained to assist the EDAEM staff in developing baseline data and preparing the final product.

The final version of the plan which was approved by the EDAEM Executive Board on May 28 in Sidney, is divided into five major components. First, the Setting and Future looks at the demographic statistics for the area and discusses the potential impact of coal development presenting population projections for the next ten years.

The Health Care System discusses three aspects of health care delivery in Eastern Montana: Health Manpower; Health Facilities, which includes hospitals and long-term care facilities; and Health Services which deals with public health, emergency medical services, alcoholism and drug abuse, and mental health.

Each section provides an inventory of services available. The Manpower and Facilities sections offer a series of alternatives available to Eastern Montana communities designed to improve their health care delivery systems.

These alternatives provide a basis for communities to determine their needs and choose a method that is best suited to meet those needs. The remaining sections develop short and long-range goals to im-

— continued on page 8

EDEAM Executive Board Approving Plan (EDEAM Photo)

Health Systems Research Institute Brings Manpower to Montana

A relatively new concept in recruitment and establishment of rural health systems is making its debut in Montana through the efforts of the Health Systems Research Institute (HSRI) of Salt Lake City, Utah.

Originating in 1973 as a project of the Intermountain Regional Medical Program, HSRI has developed a system designed to "assure high quality, uninterrupted medical care with the built-in economy of featuring little or no long-range subsidy."

The system works on a contract basis wherein the community contracts with HSRI to provide certain services including: recruiting and placing physicians who are paid a competitive salary — matching or bettering that of counterparts; a medical back-up system that could respond to a physician's call for assistance or information on a 24-hour basis; support personnel to guarantee physicians time off for recreation and continuing education, visits by specialists at the discretion and request of the rural-based physician, complete management of the out-patient facility including personnel management, and billing and collection tasks allowing the physician to devote his full time to patient care.

The "reimbursable contract" arrangement is one wherein a community interested in receiving assistance contracts with HSRI to provide the above-mentioned services. Normally, a local governmental body such as the county commissioners signs the contract for a fixed amount of money. Once HSRI sets up a physician in practice, the doctor in turn bills the patients on a fee-for-service basis. The fees are so scaled to be competitive with those charged locally by other physicians.

All fees collected then revert back to the local contracting parties such as the county. It is anticipated that such fees collectively will not match the contract amount until the physician has had sufficient time to establish a prosperous practice. Thus, the local contracting party is expected to pay the difference to fulfill their contract.

However, should the system prove successful, the community not only stands to break even over a period of time but could realize better than 100% of its fixed investment.

The first community to contract with HSRI was Battle Mountain, Nevada which enlisted the services of the Salt Lake City group in November of 1974. HSRI provided a physician and a Medex. It was estimated that at least a year would elapse before Battle Mountain reached a break even point financially.

But by February of this year, four months after the project began, Battle Mountain was taking in 118% of its contract cost; and plans are now underway to place a second physician in the community.

A second contract was written with Hawthorn, Nevada where a doctor was placed in November of last year. Similar to the Battle Mountain arrangement, the contract includes management of the out-patient clinic and a full range of support back-up and delivery components. A second physician is now being recruited for that community also.

Two Montana communities are presently engaging the services of HSRI. A contract was recently signed between Harlowton, Montana and HSRI which has placed Dr. Glenn Sheotani, M.D. in a family practice there. Another contract is expected to be signed shortly with Cut Bank.

HSRI officials are also quick to point out that all contracts are initiated with the good graces of the state and local medical societies and the boards of medical examiners. The Institute also has the backing and services of the University of Utah Medical School.

Communities can get more information on HSRI by writing:
Health Systems Research Institute,
715 E. 3900 South
Suite 205
Salt Lake City, Utah 84112.

Comings/ Goings

CHP people have been on the move with several changing positions during the summer months. In the State office, Health Planner Mary Jane Crigler left in July and moved to Seattle. Mary Jane came to Comprehensive Health Planning in 1972 and served as Health Manpower Planner prior to becoming Director of the Community Nursing Project last year.

Mary Jane Crigler

Jim Toner, Director of the South Central Regional Health Planning Council, resigned on June 20 to assume the duties of the Executive Director for the San Joaquin Comprehensive Health Planning Association of Northern California.

Jeff White, Community Planning Consultant with SCRHPC, resigned June 30, to take a planning position with the Middle Yellowstone Areawide Planning Organization.

Ralph Fruchtman

Taking over Jeff's duties will be Ralph Fruchtman, Research Assistant, who joined the SCRHPC in January. Ralph is a native of Connecticut who served as a VISTA Volunteer in Montana before going to SCRHPC.

— Continued on page 6

Centralized Services Goal of SWAHPC

Pursuing the concept of regionalization of services, the Southwestern Areawide Health Planning Council has been working with a task force from Beaverhead County to centralize its community services.

Since last December, the SWAHPC has been lending its assistance to a group composed of city and county government officials, businessmen and concerned citizens headed by Ted Hazelbaker of Dillon.

So far, Beaverhead County alcoholism, drug counseling, and mental health programs have been able to centralize their offices in the Old Barret Hospital. Advantages to the co-location is the sharing of such facilities as office space, xerox, stenographer and telephone system.

According to SWAHPC Director Jim Foley, the consolidation should increase the services to the community on a more economical basis.

Beaverhead County is sponsoring the community mental health program with $2,400 and $800 of in-kind matching funds while contributing $4,500 matching funds to the alcoholism program. Foley also mentioned that the hospital board has been most cooperative in developing the format for the shared services.

At this time, the former Barret Hospital building is housing the alcoholism counselor's office, a part-time drug outreach worker, and the community mental health office for which a full-time psychologist will be hired.

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Editor ... **Jim Jasper**

Editorial Assistant **Carolyn Gordon**

Photography ... **Jim Jasper**

Under Observation

by Dennis Taylor

PL 93-641, the National Health Planning and Resource Development Act of 1974, has begun to draw the serious attention of Montanans from all sectors of the health-policy-attentive public. Concern for the future implications of the law have focused initially on Health Service Area designation and the competition over which group will become the designated Health Systems Agency for Montana. Little attention has yet been focused on the more significant aspects of the Act. While negotiations and turf battles continue, some people are beginning to analyze the future trends highlighted by the Act. Congress has for the first time in the health policy domain begun to give indications that our scarce resources must be rationed and used effectively. In part A of PL 93-641, ten national health priorities are enumerated that reflect Congress' intent for national focus and should key important budgetary considerations in the health area. Briefly stated, Congress lists their top ten areas of concern that "deserve priority consideration" as 1. primary care for underserved areas (especially rural and economically depressed areas), 2. coordination and consolidation of services on a multi-institutional basis, 3. medical group practice and HMO's, 4. increased use of physician assistants, especially nurse clinicians, 5. multi-institutional arrangements for sharing support services, 6. quality of health services, 7. regionalization, geographical integration, 8. prevention of disease and preventive health care services, 9. improved financial management, and 10. health education.

The priorities spelled out by Congress in PL 93-641 dovetail quite nicely with the basic planning themes highlighted in HEW's **Forward Plan for Health FY 1976-1980.** This document, another significant first for national health policy, represents HEW's best effort to define and outline priority activity consistent with five major themes. The five major themes which guided the development of the **Forward Plan** are: 1. prevention; 2. preparing for National Health Insurance which includes planning, regulation, cost containment, emphasis on primary care, structural reform and a scarcity area focus; 3. quality assurance, 4. tracking health status and the health industry; and 5. knowledge development.

The composite priorities indicated by PL 93-641 and the HEW **Forward Plan for Health** represent two of the most important tools for planning purposes to date and offer specific and detailed cues to health planners and policy makers that have been noticeably absent in the past. Of special import to Montana are the priorities given to scarcity area planning, the emphasis on primary care, the promotion of physician extenders and health prevention/promotion standards. With the implementation of PL 93-641, and the direction provided by the **Forward Plan,** health planning has come of age. The linkage of health planning with implementation, which is keyed to high-yield intervention based on analysis and the recognition of different levels of planning, is indeed the wave of the future.

Montanans—especially those who keep a watchful eye on the health policy sector—will find these useful guideposts just as important, if not more so, than the designation of the HSA or other procedural aspects of the implementation of PL 93-641 in Montana. With the health policy course being charted and directions finally spelled out, the job of strategic planning for measurable intervention that will significantly improve and perfect our health care delivery system in Montana is progressing forward. The next step after the final implementation of PL 93-641 will be the development of a more specific and locally prioritized "forward plan for health in Montana."

THE MEDICAL MALPRACTICE CRISIS

SOME POSSIBLE SOLUTIONS — Short and Long-Term

Third and Final in a Series

In the absence of any generally adopted solutions to the medical malpractice crisis, the number of malpractice suits and claims continues to rise. Publicity given to higher medical malpractice settlements and judgments, based on expanding legal precedents, is likely to trigger increasing litigation while also forcing the practice of "defensive medicine."

At the same time, a lion's share of the insurance companies' cost is going to the legal profession; and the burden of premiums like the lowered quality of care must be borne by the intended "beneficiaries" of the health care system.

Although solutions are slow in coming, more and more people are attempting albeit belatedly to come to grips with the problem. Several pieces of national legislation have been prepared yet the prevailing attitude is that the malpractice problem and its solution should be a matter of state and local jurisdiction.

In the meantime, states which are facing physician strikes, absurd premium rates, and insurance companies' failure to continue offering liability coverage are struggling to find some immediate relief from a situation threatening the entire health care system.

Already 35 states have taken some form of action to curb the crisis. New York and New Jersey have passed legislation to limit the amount attorneys may receive in contingency fees for handling malpractice cases.

Maryland, New Jersey, Michigan, California, Arkansas, Idaho, Indiana and Wisconsin have passed legislation which would set up insurance pools or special funding mechanisms to guarantee liability coverage to physicians in the wake of private insurers' pulling out.

Indiana and Idaho have also passed legislation limiting the amount of money which may be awarded in a malpractice settlement. Addressing the "long tail" problem, which concerns the plaintiff's ability to sue many years after a maloccurance, Maryland has set a limit of five years within which a suit must be brought. In a similar action, Indiana is limiting to two years the amount of time allowed for filing a malpractice claim.

The 1975 Hawaii Legislature passed a bill requiring all casualty insurers in the state to form a joint underwriting arrangement if commercial insurers refuse to provide liability coverage. On the other hand, the Maryland Court of Appeals has ruled that the state cannot force an insurance company to continue its coverage.

Not all of the recently sought or enacted measures have been greeted as the malpractice messiah. A bill was passed in Maryland which would create a non-profit insurance company run by doctors. However, the head of the Maryland medical society strongly opposed the measure urging the Governor to veto it on the grounds that the company would quickly go broke without any accompanying measure to limit the size of awards.

Literally hundreds of bills have been introduced in nearly every state this year. Their complexities vary, with some bills isolating a specific problem whereas others try to combine several approaches in one bill. A total of 47 states have considered legislation relating to the malpractice situation. Montana along with Kentucky and Mississippi has yet to deal with the malpractice problem.

The situation in Montana may not be nearly as serious as the other more densely populated states such as California and New York. However, as the situation nation-wide is likely to get a lot worse before it gets better, Montana may be forced to come to grips with the problem legislatively in the 45th Legislative Assembly scheduled to meet January of 1977.

It should be noted that those measures already being taken by some states are only immediate stop gaps designed primarily to keep the situation from worsening and do not solve the malpractice maze as such. To do so will require far more than just assuring physicians that they can retain liability coverage at a reasonable cost.

The present tort system's inability to provide just compensation for patient injury as well as a reduction in the number of injuries suffered as a direct result of poor quality medical care will have to be addressed.

Some of the remedies to the problem might include voluntary reforms on the parts of the insurance, medical and legal communities along with legislative recommendations for immediate adoptions and/or further study.

Because the current malpractice situation is seen to at least encompass numerous problems, simply identifying legislative proposals that are the direct result of the current situation is difficult. These reforms have been suggested, not necessarily recommended. The following are those options most frequently proposed for state action, ranging from stop-gap short-term remedies to long-range solutions.

MEDICAL REFORMS

1. Strengthening the Medical Practices Act and Board of Medical Examiners.

2. Requiring that licensed hospitals notify the medical licensing boards of any physician's removal or suspension from their medical staffs.

3. Requiring insurance firms to notify the licensing boards of all claims, settlements, or final dispositions in malpractice cases.

4. Require complaints from the public to be referred to licensing boards for investigation.

5. Yearly license renewal for all physicians dependent on applicants taking a minimum of continuing education.

6. Include a provision in the Medical Practice Act to revoke or suspend licenses for medical incompetence.

7. Include lay members (con-

— continued on next page

sumers) on the Board of Medical Examiners.

8. Require specialty boards to recertify practitioners.

9. Require a statement of patients' rights to be distributed by physicians, hospitals, and other health care facilities.

10. Patient oriented ombudsmen in hospitals.

11. Require risk control and safety programs in hospitals.

12. Require patient grievance system in hospitals.

LEGAL REFORMS

1. Attorney's contingency fees based on sliding scale not to exceed 40% on first $5,000 recovered, 33⅓% on the next $45,000, 20% on the next $50,000 and 10% on anything over $100,000 (New Jersey Rule).

2. Consideration by the court of all sources of payment to plaintiffs before judgments are awarded to avoid duplicate compensation.

3. Changing general court rules to prohibit inclusion of dollar amounts in ad **damnum** ("to the damage") clauses in medical malpractice suits.

4. Criminal penalties for the offer or sale of treatment information about a patient without his consent.

5. Shortening the statute of limitations for medical malpractice.

6. Placing a ceiling on compensations (ex., $100,000 for death and $50,000 total disability).

7. Limiting or eliminating "pain and suffering and punitive damages."

8. Establishing funds to handle future expenses of claimants to eliminate windfall recoveries.

9. Limiting guarantees of medical results to assurances expressly set forth in writing.

10. Ruling oral statements not admissible to qualify under the terms of written informed consent.

11. Eliminating injury alone as a basis of negligence (reps ipsa loquiter).

12. Require monthly or yearly payments rather than lump sum damage awards.

13. Provide legal aid for those who cannot afford it.

INSURANCE REFORMS

1. Adoption of a "claims-made" form of insurance policy.

2. Joint underwriting associations.

3. Improve reporting system to Insurance Commissioner.

a. Hospital and doctors required to report injury.

b. Insurance carrier required to report claim and settlement.

c. Lawyers required to report claim and settlement or final disposition in malpractice cases.

4. State fund to insure payment of settlements or awards by a jury over a fixed sum (ex., $300,000).

5. Require all insurance carriers in state to share responsibility for underwriting medical malpractice insurance.

One option that is being considered as a possible long-range solution is that of "no-fault" medical malpractice insurance. Similar to the no-fault auto insurance, the concept is to focus on compensating the victim for the bad result rather than fixing blame on the cause for that result.

Proponents of a no-fault system argue that this method would better insure that the patient is compensated and would take some of the emotional overtones as well as the courtroom theatrics out of the medical malpractice realm.

Opponents meanwhile charge that no-fault would do more to jeopardize the quality of care that patients receive because physicians would not be held accountable for shoddy practice. The proponents respond to this charge by saying that after each experience the physician will undergo rate hikes in his insurance much like auto insurance, but as far as policeing the practice this would still be up to peer review and/or regulatory boards.

Two questions that are usually posed concerning no-fault are how can it insure cost control and what constitutes a compensable event? Causation of medical injuries is usually not as simple to determine as in auto accidents.

Another option is screening panels. In some states these panels already are employed and they have proven successful to some extent in reducing the number of cases which end up in court. Theoretically the screening panel is designed as a neutral body of experts who hear both sides of the dispute and based on the evidence presented recommend that the issue be settled or withdrawn.

Among the problems of the screening panels is that they do not make binding decisions. They merely give advice such as recommending that the insurance companies settle in a particular case because the plaintiff has a legitimate grievance or that the plaintiff drop the case for lack of merit.

Another problem is that insurers see such panels as detrimental inasmuch as it causes them to reveal their defense while facing a possible court action.

Another long-range solution advocated by some is a form of binding arbitration akin to the system used in solving labor disputes. The system would operate by both parties — plaintiff and defendent — choosing an arbitrator. The two chosen arbitrators would in turn choose a mutually acceptable, third arbitrator.

At the outset of the hearing, both parties would agree to abide by the decision of the arbitration panel thus excluding the possibility of further litigation. The hearing would be closed without cross examination and publicity.

Advantages to the arbitration system would be review by a panel of experts rather than a lay jury and a reduction in the number of cases brought to court. However, opponents of arbitration claim that the system favors providers because arbitration in such disputes as labor contracts involves parties of equal bargaining strength as opposed to a maloccurance question in which one party has suffered damages.

A final solution being offered is that of a form of compensation similar to that of Workmens' Compensation. Under such a system, the emphasis would be on equitable compensation for injury. Again, the issue of causation or negligence would not be addressed. Proponents view compensation as an opportunity to eliminate the adversary relationship between provider and patient and reduce the number of cases going to court.

The biggest question mark in the development of such a system would be the financing mechanism. Most likely, the government would administer the program funded through taxation similar to the Social Security System.

New Planning Division Formed

The Department of Health and Environmental Sciences has implemented an internal reorganization representing an effort to improve the efficiency and effectiveness of the programs combined by Public Law 93-641, the National Health Planning and Resources Development Act of 1974. Basically, the reorganization provides a more effective link between health planning and health implementation — a link which has been lacking in the past.

The reorganization combines the Division of Comprehensive Health Planning and the Construction Bureau formerly located within the Division of Hospital and Medical Facilities. The Division is headed by Robert R. Johnson, Administrator, who previously served as Administrator of the now defunct Division of Comprehensive Health Planning. The new Division is composed of two bureaus: Health Planning and Resource Development.

This reorganization is the result of an analysis of the aforementioned National Health Planning legislation. That legislation calls for a much closer relationship between planning and implementation. The Denver Regional office reviewed this reorganization and has indicated that it would substantially meet the requirements of the new legislation.

A realignment of existing programs and budgets, the reorganization does not create any new or additional programs and does not require any additional state funds for its effective implementation.

The Health Planning Bureau, headed by acting Bureau Chief Leslie Taylor, includes provision for three health planning roles: one specializes in the development of the health facilities and services component of the State Plan for Health thereby meeting the requirements of the Medical Facilities Construction program; and the remaining planner serves as a coordinator, allowing for input of environmental health needs in addition to assisting the two more experienced planners in developing a comprehensive state health plan. Coordinating the technical aspects of health planning with the HSA is a responsibility of this Bureau in addition to developing the evaluation component for the Division and providing consulting assistance to the Health Resources Development Unit. This type of assistance would also be available to other parts of the Health Department and other programs within the State. Health data coordination and development would also be a responsibility of this Unit.

The Health Resources Development Bureau, headed by Bureau Chief Wally King, is responsible for a variety of functions considered developmental in nature and necessitated by the planning legislation. Comment and review responsibilities assigned to the State level planning and development office by the new planning legislation would be included within this Bureau. A total of two staff positions will handle the comment and review responsibilities.

Other functions included within this Bureau are HSA activity coordination, implementation capability of a broad functional nature, grantsmanship capability, legislative coordination, and technical consultation for Medical Facilities Construction. All of these tasks are necessary if implementation of the plan developed by the HSA and the State Health Planning Bureau is to be taken seriously. The Health Resources Development Bureau included a total of six staff positions including Program Manager.

The implementation of this proposal will cost the State no more funds than are presently budgeted for the combined programs. The staff of the new Division for the most part is already employed by the Department, and no new programs are created by this proposal.

This proposal responds to a need to design a more effective approach to health plan development and implementation and a more economical and easily understood process for conducting our comment and review responsibilities.

Around the State

Ann Guthals formerly employed by the Northwestern Montana Areawide Health Planning Council as an Associate Health Planner assumed the duties of Executive Director of the South Central Regional Health Planning Council on July 7. Ms. Guthals replaced former Executive Director Jim Toner.

The SCRHPC's staff now includes Ms. Guthals; Peter Guthridge, Community Organization Specialist—YCCS; Ralph Fruchtman, Research Assistant; and Melody Wickham and Kim Best, secretarial staff.

* * *

Also in South Central Regional Health Planning Council the Project Review Committee held a special meeting on May 13, 1975, to review the proposal for the addition of an axial tomography service in Columbus Hospital, Great Falls. The Designated Planning Agency (DPA) had requested that SCRHPC conduct an 1122 review of the proposal because it (the DPA) felt that the equipment could "potentially serve the entire population of the state."

The Committee extended invitations to appropriate professionals in order to make them aware of the special meeting and to receive their comments.

The Committee concluded that the addition of an axial tomography service in Great Falls would not be sufficient to serve the South Central Area and the Billings health service area. The Committee went on to declare the Great Falls proposal to be nonsubstantive since it felt that such a service **should not affect** the South Central Area.

COMINGS **from page 2**

Helen Strand, former Health Planner for the Economic Development Association of Eastern Montana, has moved to Missoula where she has joined the staff of the Northwestern Areawide Health Planning Council.

New Utilization Review Bills Not to Affect Montana Facilities

There may be some confusion on the part of Montana hospitals on just how they will be affected by three bills currently before Congress which, if enacted, would offer some relief from the increased workloads placed upon rural facilities by regulations governing utilization review. The bills representing a precedent for recognition of problems particular to small hospitals, actually will not affect Montana at all.

The regulations, which were published in the Federal Register last November and scheduled to take effect on July 1, 1975, were designed for the control of utilization. Proponents of HR 5390, HR 3716, and SB 843, claim that those regulations are written with the capabilities of large, urban hospitals in mind and do not take into consideration the small staffs and limited budgets of small rural facilities.

The bills would grant waivers to such small hospitals for up to 18 months during which time a study would be conducted to devise alternative methods of meeting the requirements.

According to David Coyner, Executive Director of the Montana Foundation for Medical Care, the legislation would not affect Montana at all. "The bills are designed to address only the interim utilization regulations published last November, and those regulations are superceeded by the Professional Standards Review Organization (PSRO) regulations."

The Montana Foundation for Medical Care is the conditional PSRO in Montana.

Coyner added, "It is important that the hospitals realize that this new legislation will only affect those states and areas that do not have conditional PSRO's."

One element of the legislation that is significant to rural health professionals is the three-point criteria defining a rural hospital: "1) . . . There is no other community which has a population of fifty thousand or more within a ten-mile radius of such a hospital; 2) the combined average patient load for all hospitals within such ten-mile radius is less than forty per day; and 3) the number of practicing physicians on the regular staff of such hospital does not exceed seven."

Bill Leary, Executive Director of the Montana Hospital Association, views the legislation as significant in recognizing the limitations that small, rural facilities have in meeting federal requirements.

"We have always worked for legislation that might give a waiver for small facilities. It just costs these hospitals too much money to comply with the regulations. Although the bills don't affect Montana, due to the efforts and acceptability of the conditional PSRO, at least it is being recognized that there is a different concept for the small hospitals."

Leary emphasized that he would not favor a blanket waiver or doing away with the regulations. "Utilization review is basically good, but it should be based upon the number of doctors on staff. Exemptions should be based on the basis of the facilities' being able to verify a need for it," Leary said.

Concerning nursing homes, it will be approximately another year before the PSRO will be conducting their utilization reviews. During that time, utilization review for nursing homes will continue to be monitored by the Hospital and Medical Facilities Division of the State Department of Health and Environmental Sciences.

According to the Division's Administrator, George Fenner, "The regulations issued on July 14, 1975, do pertain to nursing homes as well as hospitals. Nursing homes can submit their plans for compliance with the Hospital and Medical Facilities Division and we will send it on to HEW (Department of Health, Education and Welfare)."

Mr. Fenner also indicated that the Division will continue to monitor a sample of hospitals as directed by HEW. About 10% of the state's hospitals will be chosen by HEW to constitute the sample Fenner said.

Although Montana will not be affected by the legislation, it is a step forward in as much as small, rural facilities are becoming recognized as an entirely different situation than their major urban counterparts.

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Treasure State corporation is afraid will be taken out of local hands.

Although Montana has been declared a single Health Systems Agency, there is still an option that "sub-area" councils might exist to provide local input. Yet input and decision-making are not necessarily synonymous. "If sub-area councils can not make decisions, then there really isn't much use in having them," Morse said.

Bill Leary, Executive Director of the Montana Hospital Association, has been assisting in the development of the Montana Health Systems Agency. According to Leary, the circumstances surrounding the formation of the provider organization have caused it to overlook local input.

"I think that the reason why we have not had representation of rural people is because the people who started Montana Health Systems were primarily from the Helena area. But we have not lost contact with the fact that there has to be some rural input into any kind of a system. This is where some of the real problems in the health care system are," Leary stated.

Still, although the providers seem eager to elicit local input, it doesn't appear that Montana Health Systems is considering localized decision-making. But Leary is quick to point out that although Montana Health Systems will be Helena-located, he does not foresee the organization being Helena-dominated.

"This is where the Treasure State people can lend their input by saying 'now let's not forget that Montana is a rural state and we cannot have this completely run or dominated by a centralized area.' "

Morse and the other members of the Treasure State Organization are afraid that an organization centered in Helena would be another bureaucracy with which rural residents would have little or no contact.

Leary, while admitting that the

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Montana Health Systems Agency has not had much local input as yet, views such an organization as having considerably more power to get things done.

Says Leary, "I think that the Montana Health Systems Agency will have more political clout because of the people and particularly the consumers who will be involved. And a big difference will be the shying away from consumers who are low income — that is probably the big difference between the two organizations. The providers will be hand-picking the consumers who are knowledgeable in their communities, but they may not be low-income."

Although sceptical of the local impact of "just another centralized bureaucracy," Morse noted the possible impact that a strong provider group may have particularly with federal regulations governing health planning.

"The providers want an organization strong enough that the Feds will recognize it," Morse said adding, "I think they would want to deal with local people who they know and can talk to. After the HSA is operating, maybe they can get the Feds to understand our situation and loosen up a little on the regulations; maybe this is what the providers are thinking."

Both Morse and Leary were asked if they considered the new Health Planning and Resource Development Law to be a good piece of legislation improving health planning over the old CHP and RMP programs.

Said Leary, "I don't think the law was written with the intent of Montana, Idaho, North and South Dakota in mind. The people who wrote the law have no concept of the problems that we have out here.

"I can see it as an improvement if it will reinstitute in some of the key providers the need for health planning and involvement," Leary stated.

Morse is also reserved about citing the new law as the harbinger of salvation for health planning problems in the state. "I don't know if the new law is going to do that much. I do know that a lot more money is going to be spent if that is an improvement. At least under the old law we did have some decision-making on our level even though the decisions were not final ones," he said.

Reflecting on the past, both men agreed that Comprehensive Health Planning had served a purpose that was clearly not mandated to be highly effective politically.

"CHP was a good start because CHP did identify a lot of problems the people were talking about. CHP went as far as it could, but it was never designed to be a strong political-type of organization," Leary said.

Morse added, "We didn't have as much provider input under CHP as we should have. The new law will force more dialogue between providers and consumers. But whether it will be that much better, I just don't know."

No doubt the future of health planning in Montana will depend as much if not more on the personalities involved than the new law. And it is not unlikely that an alliance of sorts will be formed among all the groups that are and should be involved in health planning.

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Morse—"Local decision-making"

PLANS from page 1

prove the delivery of services in Eastern Montana.

The section entitled Cost and Financing of the Health Care System presents a brief discussion of health care financing and a short analysis of potential impacts on the cost and financing of health care systems such as National Health Insurance and Health Maintenance Organizations (HMO's).

The Montana CHP Agency's strategy for implementing the plan is outlined in the implementation section. A work program is given for the Manpower, Facilities, and Services Sections. Recommendations in the plan are accompanied by definitive tasks which should be undertaken to implement those recommendations.

Drafts of the plan were submitted to all area health providers including doctors, nurses, and hospital administrators for comment. Each draft was revised and commented upon at public meetings at which considerable input was received. Drafts also were made available for public review at county libraries, city halls, county commissioners' and county extension offices.

Areawide health planning provides a forum for local citizens to come together and prepare for their future health needs by collecting necessary data and preparing a written document which can be used as a yardstick to guage proposed alternatives to the existing health system.

The North Central Montana Health Planning Council and the Southwestern Areawide Health Planning Council have also recently completed and published their health plans. The Northwestern Areawide Health Planning Council will publish its plan within a few weeks.